Health Plan Summary

Regular and Local 587 Employees

King County
Benefits and Retirement Operations

Medical

The following table summarizes the features and covered expenses of the three medical plan options. As you compare the KingCare℠ Basic and Preferred plans, please note that the only advantage to Basic is lower premiums for employees who pay for medical coverage (employees in Part-Time Local 587 Partial Benefits Plan, COBRA participants and retirees); regular employees, full-time Local 587 employees and employees in Part-Time Local 587 Full Benefits Plan don't pay for medical coverage.

Also please note that two separate companies process claims for the KingCare℠ plans. If you chose a KingCare℠ plan, you receive a medical card from Aetna to use for all medical claims (physician visits, hospital, lab work, etc.) and a prescription card from Caremark (formerly AdvancePCS) to use for all outpatient, retail pharmacy and mail order prescription drug claims.

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers	You may choose any qualified provider, but you receive higher coverage when you use network providers	You choose a Group Health primary care physician (PCP) who provides and coordinates most services through the Group Health network; you may also self-refer to Group Health staff specialists; no non-network coverage unless indicated
Annual deductible	$500/person, $1,500/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible	$100/person, $300/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible	None
Copay/office visits	No copays, but you pay coinsurance	No copays, but you pay coinsurance	You pay $20
After the deductible/copays, the plans pay most covered services at these levels until you reach the annual out-of-pocket maximum	80% network medical claims (you pay 20% coinsurance) 60% non-network medical claims (you pay 40% coinsurance)	90% network medical claims (you pay 10% coinsurance) 70% non-network medical claims (you pay 30% coinsurance)	100% network Limited emergency/out-of-area non-network care
Annual out-of-pocket maximum	$1,200/person, $2,400/family network (plus deductible) $2,000/person, $4,000/family non-network (plus deductible)	$800/person, $1,600/family network (plus deductible) $1,600/person, $3,200/family non-network (plus deductible)	$1,000/person, $2,000/family network and limited emergency/ out-of-area non-network
After you reach the out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	100% network	100% network	100% network

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Lifetime maximum	$2,000,000	$2,000,000	No limit
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	80% network 60% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits	90% network 70% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits	Self-referrals to a network provider are covered up to 8 visits/medical diagnosis/ calendar year for acupuncture and up to 3 visits/medical diagnosis/calendar year for naturopathy; except for chiropractic services, all other alternative care may require PCP referral All services are subject to the $20 copay/visit
Ambulance services	80%	90%	80% (except hospital-to-hospital ground transfers covered 100% when initiated by Group Health)
Chemical dependency treatment	80% network 60% non-network $12,500 (2005)/$13,000 (2006) maximum/24 consecutive months for combined network and non-network services when preauthorized (maximum subject to annual adjustment)	100% network 70% non-network $12,500 (2005)/$13,000 (2006) maximum/24 consecutive months for combined network and non-network services when preauthorized (maximum subject to annual adjustment)	100% after $200 copay/admission for inpatient care 100% after $20 copay/visit for outpatient care $12,500 (2005)/$13,000 (2006) maximum/24 consecutive months (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	80% network 60% non-network Up to 33 visits/year for combined network and non-network services	90% network 70% non-network Up to 33 visits/year for combined network and non-network services	100% after $20 copay/visit
Diabetes care training	80% network when prescribed by your physician 60% non-network when prescribed by your physician	90% network when prescribed by your physician 70% non-network when prescribed by your physician	100% after $20 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	80% when preauthorized	80% if authorized in advance by a network provider as medically necessary

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Emergency room care	80% after $50 copay/visit (waived if admitted) for network or non-network emergency care 80% network, 60% non-network after $50 copay/visit for non-emergency care	90% after $50 copay/visit (waived if admitted) for network or non-network emergency care 90% network, 70% non-network after $50 copay/visit for non-emergency care	100% after $75 copay/visit to network facility ($75 copay is waived but $200 copay/ admission for hospital care applies if admitted) 100% after $125 copay/visit to non-network facility ($125 copay is waived but $200 copay/ admission for hospital care applies if admitted) Non-emergency care not covered
Family planning	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit (infertility treatment not covered)
Hearing aids	100% up to $500 in 36 months for combined network and non-network services	100% up to $500 in 36 months for combined network and non-network services	100% up to $300/ear in 36 months
Home health care	100% when preauthorized up to 130 visits/year for combined network and non-network services	100% when preauthorized up to 130 visits/year for combined network and non-network services	100%
Hospice care	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period	100% when preauthorized Certain limits apply; call plan for details
Hospital care (not in an emergency room)	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized	100% after $200 copay/admission
Lab, x-ray and other diagnostic testing	80% network 60% non-network	90% network 70% non-network	100%
Maternity care	80% network 60% non-network	90% network 70% non-network	100% for delivery and related hospital care after $200 copay/admission 100% after $20 copay/visit for prenatal and postpartum care
Mental health care	80% network, 60% non-network for inpatient up to 30 days/year (combined network and non-network services) 80% network, 60% non-network for outpatient up to 52 visits/year (combined network and non-network services)	90% network, 70% non-network for inpatient up to 30 days/year (combined network and non-network services) 90% network, 70% non-network for outpatient up to 52 visits/year (combined network and non-network services)	100% after $200 admission copay per visit, up to 12 days/year for inpatient 100% after $20 copay/individual, family, couple or group session, up to 20 visits/year for outpatient

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Neurodevelopmental therapy for covered family members age 6 and under	80% network when preauthorized 60% non-network when preauthorized $2,000/year maximum for combined network and non-network services	90% network when preauthorized 70% non-network when preauthorized $2,000/year maximum for combined network and non-network services	100% for inpatient services after $200 copay/admission up to 60 days/year (combined with rehabilitative services) 100% after $20 copay/visit for outpatient services up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage while traveling, for your children away at school, etc.	Same coverage as when home, through Aetna and Caremark national provider networks	Same coverage as when home, through Aetna and Caremark national provider networks	Reciprocal benefits available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out-of-area
Physician and other medical/surgical services	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit
Prescription drugs – up to 30-day supply through network pharmacies	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) (Prescriptions filled at non-network pharmacies reimbursed at the rate Caremark pays to network pharmacies, less your copay)	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) (Prescriptions filled at non-network pharmacies reimbursed at the rate Caremark pays to network pharmacies, less your copay)	100% after $10 copay for generic 100% after $20 copay for preferred brand 100% after $30 copay for non-preferred brand (No reimbursement for prescriptions filled at non-network pharmacies)
Prescription drugs – up to 90-day supply through network mail order	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take it for medical reasons, the $50 copay applies)	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take it for medical reasons, the $50 copay applies)	100% after $20 copay for generic 100% after $40 copay for preferred brand 100% after $60 copay for non-preferred brand
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc. per plan schedule; immunizations for travel aren't covered)	100% network 60% non-network	100% network 70% non-network	100% after $20 copay/visit

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Radiation therapy, chemotherapy and respiratory therapy	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy, including lymphedema; call plans for more information)	80% network 60% non-network	90% network 70% non-network	100% depending on services provided; copays may apply (including $200 copay/ admission if hospital care required)
Rehabilitative services Inpatient and outpatient	80% network 60% non-network Up to 60 days/year for inpatient; up to 60 visits/all therapies combined for outpatient (progress review every 20 visits for non-network outpatient)	90% network 70% non-network Up to 60 days/year for inpatient; up to 60 visits/all therapies combined for outpatient (progress review every 20 visits for non-network outpatient)	100% for inpatient services after $200 copay/admission up to 60 days/year (combined with neurodevelopmental therapy) 100% after $20 copay/visit for outpatient services up to 60 visits/year (combined with neurodevelopmental therapy)
Skilled nursing facility	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized	100% up to 60 days/calendar year at a Group Health-approved nursing facility
Smoking cessation	100% network services 60% non-network services Prescription drugs to ease nicotine withdrawal, inhalers and sprays covered by Caremark at 100% (no copay); non-prescription nicotine patches and gum covered by Aetna at 100%	100% network services 70% non-network services Prescription drugs to ease nicotine withdrawal, inhalers and sprays covered by Caremark at 100% (no copay); non-prescription nicotine patches and gum covered by Aetna at 100%	100% for 1 Group Health network provider program/year 1 course of nicotine replacement/year (prescription benefit copay applies) when prescribed by Group Health network provider if the member is actively participating in Free and Clear Program
Transplants (certain services only)	100% network when preauthorized 60% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare℠ plan – whether preexisting or an emergency	100% network when preauthorized 70% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare℠ plan – whether preexisting or an emergency	100% after applicable copays Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or an emergency
Urgent care (ear infections, high fevers, minor burns, etc.)	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit

Dental

Dental coverage is provided by Washington Dental Service. You can use any dentist you wish, but the benefits are generally higher (your out-of-pocket expenses are less) and the dentist automatically files your claim if you see a WDS dentist (most dentists in Washington participate in the WDS plan).

WDS increases your payment levels through an incentive program as long as you see your dentist each year:

- For diagnostic and preventive services as well as basic services, the payment level starts at 70% and increases 10% in January of each year until you reach 100% (if you don't see the dentist during the calendar year your payment level is reduced to the next lower payment level, but never below 70%)
- For major restorative services the payment level increases from 70% to 80%, then to 85%.

If you're a new hire, coverage begins at the 70% incentive level; levels "earned" under another group plan don't apply to the county plan. However, incentive levels are adjusted based on previous participation in the county plan if you're a:

- Recalled or reinstated employee
- Rehired employee who's continued county coverage uninterrupted under COBRA between your previous county employment and rehire (if county coverage has been interrupted, new hire incentive levels apply).

Washington Dental Service	
Annual deductible (doesn't apply to diagnostic and preventive services, orthodontic services or accidental injuries)	$25/person, $75/family
Annual maximum benefit (doesn't apply to orthodontic or TMJ services)	$2,000/person
Covered Expense	**WDS Pays**
Diagnostic and preventive services (exams, cleanings and x-rays)	70%-100% based on patient's incentive level (deductible doesn't apply)
Basic services (crowns, extractions, fillings, etc.)	70%-100% based on patient's incentive level
Major services – restorative (crowns and onlays)	70%-85% based on patient's incentive level
Major services – prosthodontics (dentures, fixed bridges and implants)	70% (incentive levels don't apply)
Orthodontic services for adults and children	50% up to a $2,500 lifetime maximum (deductible and incentive levels don't apply; benefit doesn't apply to the annual maximum benefit)
Night (occlusal) guards	50% (incentive levels don't apply; your medical plan may provide additional coverage)
Temporomandibular joint (TMJ) disorders	50% up to a $500 lifetime maximum for non-surgical treatment and appliances (incentive levels don't apply and this benefit doesn't apply to the annual maximum benefit; your medical plan may provide additional coverage)
Accidental injury	100% for covered expenses incurred within 180 days of accident (deductible doesn't apply)

Vision

Vision coverage is provided by Vision Service Plan. You can use any eye care provider you wish, but the benefits are generally higher (your out-of-pocket expenses are less) and the provider automatically files your claim if you see a VSP provider. (Group Health provides routine vision exams under its medical plan, but none of the other vision benefits listed below; VSP providers may not accept a Group Health prescription for lenses.)

Vision Service Plan		
Covered Expenses	If you see a VSP provider you pay a $10 copay and the plan pays ...	If you see a non-VSP provider you pay the bill in full and the plan reimburses you the following amounts, minus a maximum $10 copay ...
Exams (once every 12 months)	100%	Up to $40
Lenses (1 pair every 12 months)		
● Single vision	100%	Up to $40
● Bifocal	100%	Up to $60
● Trifocal	100%	Up to $80
● Lenticular	100%	Up to $125
● Polycarbonate for children	100%	Not covered
● Progressive	100%	Up to $5 for upgrade to progressive, tints and coatings combined
● Tints	100%	
● Coatings	100%	
Frames (once every 24 months)	Covered up to $130; if you chose a frame that costs more then the VSP allowable amount, you'll receive 20% off your out-of-pocket costs	Up to $45
Contacts (once every 12 months in place of eyeglass lenses and frames)		
● Elective	100% up to $105	Up to $105
● Medically necessary	100%	Up to $210